MDR: M4-02-2275-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $905.81 for dates of service 06/20/01, 07/20/01, and 08/30/01.

   b. The request was received on 02/11/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. HCFA(s)
   c. TWCC 62 forms/Medical Audit summary dated 11/30/01 for dos 08/30/01.
   d. EOB(s) from other insurance carriers
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. HCFA(s)
   c. TWCC 62 form/Medical Audit summary dated 11/30/01
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. This case file contains no carrier representative sign sheet. The provider's initial request for dispute was received 02/11/02. The carrier's three day response to the initial request was received 02/14/02. No other response are included in this case file. The Respondent did not submit a response to the request. The "No Response Submitted" sheet is reflected in Exhibit II of the Commission's case file.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states on the Table of Disputed Services, "We feel that we are due total and Full ReimbursementS [sic] for the external durable medical equipment. We billed for the 'Rental' of this equipment not purchase and we have not been Reimbursed [sic] accordingly. We are requesting Additional [sic] payments In [sic] full with interest."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 06/20/01, 07/20/01, and 08/30/01.

2. The carrier denied the billed charges by denial codes, "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011 (B)." and "INT – G – 04/01/96 TWCC MEDICAL FEE GUIDELINE GROUND RULES INDICATE THAT THIS SERVICE IS AN INTEGRAL COMPONENT OF ANOTHER SERVICE, PROCEDURE, OR PROGRAM. SEPARATE REIMBURSEMENT IS NOT ALLOWED FOR THIS PROCEDURE."

3. The Medical Audit dated 11/30/01 referencing date of service 08/030/01 states, "The amount paid in July for this unit was for purchase, not rental. Therefore, additional rental of the unit is not allowed."

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
06/20/01	E0731	$495.00	$289.19	M	DOP	Rule 133.307 (g) (3) D); Rule 413.011 (d); MFG DME GR (IV); MFG GI (VI); CPT descriptor	The carrier denied the charges by denial codes "M" and "G". The carrier's three day response contains the same EOB(s) and Medical Audit as was submitted in the provider's request for medical dispute. Therefore, the Medical Review Division's decision is rendered on those denial codes submitted to the provider prior to this dispute being filed. The provider failed to meet the criteria of 133.307 which states, "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title…" The MFG GI (VI) states, "CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at fair and reasonable rate…" As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. In this case the provider submitted EOB(s) from other insurance carriers, but the documentation submitted is insufficient to determine if the charge of the provider is fair and reasonable. The provider failed to meet the criteria of 413.011(b). **No** additional reimbursement is recommended.

07/20/01	E0745 RR	$475.00	$0.00	G	DOP	MFG GI (VIII) (A); CPT descriptor	The carrier denied the charges by denial codes "G". The carrier's three day response contains the same EOB(s) and Medical Audit as was submitted in the provider's request for medical dispute. Therefore, the Medical Review Division's decision is rendered on those denial codes submitted to the provider prior to this dispute being filed. The descriptor of the E0745 submitted by the provider appears to reinforce that the DME is not global to another procedure. However, in accordance with the MFG GI (VIII), the provider used a modifier NOT approved by TWCC for DME. MFG GI (VIII) (A) states, "A modifier provides the means by which the reporting HCP indicates a service or procedure performed that has been altered by some specific circumstances but not charged in its definition or code…**TWCC modifiers may differ from the those published by the American Medical Association, and in submitting workers' compensation billing, only the modifiers set out in this Medical Fee Guideline shall be used.**" The provider used the modifier "RR" for E0745. The TWCC approved modifier for "RR" is used with CPT code 99499 for "postoperative monitoring." **No** reimbursement is recommended.
08/30/01	E1399 RR	$225.00	$0.00	G	DOP	Rule 133.305 (g) (3) (B); MFG GI (VIII) (A); CPT descriptor	The carrier denied the charges by denial codes "G". The carrier's three day response contains the same EOB(s) and Medical Audit as was submitted in the provider's request for medical dispute. Therefore, the Medical Review Division's decision is rendered on those denial codes submitted to the provider prior to this dispute being filed. The provider failed to submit any documentation or description for E1399, therefore, it is impossible to determine if the DME is global to another procedure or service. In accordance with the MFG GI (VIII), the provider used a modifier NOT approved by TWCC for DME. MFG GI (VIII) (A) states, "A modifier provides the means by which the reporting HCP indicates a service or procedure performed that has been altered by some specific circumstances but not charged in its definition or code…**TWCC modifiers may differ from the those published by the American Medical Association, and in submitting workers' compensation billing, only the modifiers set out in this Medical Fee Guideline shall be used.**" The provider used the modifier "RR" for E1399. The TWCC approved modifier for "RR" is used with CPT code 99499 for "postoperative monitoring." **No** reimbursement is recommended.
Totals		$1,195.00					The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 1st day of May 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.